Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

STAR ANESTHESIA PA
45 NE LOOP 410 SUITE 900
SAN ANTONIO TX 78216

Respondent Name
WEST AMERICAN INSURANCE CO

Carrier's Austin Representative Box
Box Number 01

MFDR Tracking Number
M4-11-3668-01

MFDR Date Received
JUNE 23, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "See attached forms"

Amount in Dispute: $46.17

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 23, 2010	CPT Code 00630-AA	$46.17	$46.17

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, effective March 1, 2008, 33 TexReg 626, sets out the fee guidelines for reimbursement of professional medical services provided in the Texas workers' compensation system.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 93-Paid: no modification to the information provided on the medical bill: payment made pursuant to contractual agreement.
   - P303-This contracted provider or hospital has agreed to reduce this charge below fee schedule or usual and customary charges for your business.
   - Any reduction is in accordance with the FOCUS-Aetna Workers Comp Access LLC contract.
   - Z664-Reimbursement is calculated using base units plus time units.

- Z611-Charges exceed maximum allowance or usual and customary.

Issues

1. Does the submitted documentation support that a contractual agreement issue exists in this dispute?
2. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason codes "93 and P303." Review of the submitted information finds insufficient documentation to support that the disputed services are subject to a contractual agreement between the parties to this dispute. The above denial/reduction reasonsare not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines
2. 28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   28 Texas Administrative Code 134.203(b)(1) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   28 Texas Administrative Code §134.203(c)(1) states, "…To determine to MAR for professional services, system participants shall apply the Medicare payment policies with minimal modification…For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $53.68…"

   The requestor billed the disputed anesthesiology service using the "AA" modifier that is described as "Anesthesia services performed personally by anesthesiologist."

   To determine the MAR the following formula is used: (Time units + Base Units) X Conversion Factor = Allowance

   The Division reviewed the submitted anesthesia report and finds the anesthesia was started at 0745 and ended at 0932, for a total of 107 minutes. Per Trailblazers Health Enterprises, LLC 2010 Anesthesia Manual "The 15-minute time interval will be divided into the total time indicated on the claim. Total time should always be accurately reported in minutes. Actual time units will be paid; no rounding will be done up to the next whole number – only round to the next tenth." Therefore, the requestor has supported 107 minutes /15 = 7.13, rounded to 7.1 units billed.

   Per 28 Texas Administrative Code §134.203(b)(1) the base unit for CPT code 00630 is 8.

   The MAR for CPT code 00630-AA is: Base Unit 8 + Time Unit 7.1 = 15.1 X $54.32 conversion factor = $820.23. Previously paid by the respondent is 774.06. The difference between the MAR and amount paid is $46.17.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $46.17.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $46.17 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		05/23/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.